INFORMATIONAL LETTER NO. 768

To: Iowa Medicaid Physician, Dentist, Advanced Registered Nurse Practitioner, Therapeutically Certified Optometrist, Clinic, Podiatrist, Pharmacy, Home Health Agency, Rural Health Clinic, Skilled Nursing Facility, Intermediate Care Facility, Community Mental Health, Family Planning, Residential Care Facility, Intermediate Care Facility for Mental Retardation (ICF/MR), Community Based ICF /MR Providers

From: Iowa Department of Human Services, Iowa Medicaid Enterprise

Date: December 1, 2008

Subject: Iowa Medicaid Pharmacy Program Changes

Effective: **January 1, 2009**

1. Changes to the Preferred Drug List (PDL)[1]

Preferred	Non-Preferred	Recommended
Androgel Pump®	Ambien CR®[1]	Novoseven® RT
Azor™[1]	Coreg CR®	
Ciloxan®	Depakote®[2]	
Divalproex Sodium EC	Eplerenone[1]	
Humalog®	Fenoglide™	
Humalog®Mix 75/25™	Galantamine[3]	
Humira® Chrohns Starter Package[1]	Innohep®[1]	
Humulin® 70/30	Iquix®	
Humulin® N	Lunesta®[1]	
Humulin® R	Maxalt® Tablets[1]	
Keppra XR™	Quixin®	
Lantus®	Relistor™	
Lantus® Opticlick[1]	Renvela®	
Lantus® Solostar®[1]	Stavzor™	
Lialda™	Tev-Tropin®[1]	
Oxcarbazepine	Trileptal®[2]	
Pravastatin[4]	Vytorin®	
Treximet™[1]	Xopenex® Nebulizer	
	Zamicet™	
	Zymar®	

[1] Clinical PA Criteria Apply
[2] Grandfather for seizure disorder- Automatic Point of Sale (POS) look-back for existing users
[3] POS Age Edit- Restricted to persons 40 years of age and older
[4] All strengths are preferred

2. **Preferred Brand Name Drugs on the PDL-Pharmacy Clarification**
   - When a status change occurs for a previously preferred brand name drug to non-preferred status, up to a *minimum* of 30 days transition period is given to pharmacies to help utilize existing brand name product in stock in an effort to decrease a pharmacy's remaining brand name drug inventory (see PDL comment section regarding transition periods exceeding 30 days).
   - If additional stock remains beyond this time period, pharmacies may call the POS Helpdesk at 877-463-7671 or 515-725-1107 (local) to request an override for the non-preferred brand name drug with a recent status change.

3. **Drug Prior Authorization**

   a. Changes to Existing Prior Authorization Criteria – See complete prior authorization criteria posted at www.iowamedicaidpdl.com under the Prior Authorization Criteria tab.

   - **Extended Release Formulations:** The addition of *Luvox® CR* to this prior authorization, in addition to Seroquel® XR.
   - **Growth Hormone:** Annual bone age testing is required only for a diagnosis of growth hormone deficiency. *A diagnosis of Idiopathic Short Stature(ISS) is considered not medically necessary and requests will be denied.*
   - **Linezolid (Zyvox®):** Prior to consideration of Zyvox®, a *patient must have an active infection* and is being treated for one of the following diagnoses: Vancomycin-resistant Enterococcus (VRE) and no alternative regimens with documented efficacy, Methicillin-resistant Staph aureus (MRSA) and patient is intolerant to vancomycin, Methicillin-resistant Staph epidermis (MRSE) and patient is intolerant to vancomycin.
   - **Serotonin 5-HT1-receptor Agonists-** Prior authorization is required for preferred serotonin 5-HT1-receptor agonists for *quantities exceeding 12 unit doses of tablets, syringes, or sprays per 30 days*.

   b. New Prior Authorization Criteria – See prior authorization criteria posted at www.iowamedicaidpdl.com under the Prior Authorization Criteria tab.

   - **Vusion™ Ointment:** Prior Authorization is required for Vusion™ Ointment. Payment will only be considered for cases in which there is documentation of previous trials and therapy failures with 1) over-the-counter miconazole 2% cream (payable with a prescription) AND 2) nystatin cream or ointment, unless evidence is provided that use of these agents would be medically contraindicated.

4. **Tablet Splitting:** A new Point of Sale (POS) tablet splitting edit will be in place for Lexapro® 5mg and Lexapro® 10mg tablets. Tablet splitting will be required for Lexapro® 5mg and Lexapro® 10mg at once daily dosing. Following is an example of a POS rejection message for this edit:

	Number and Message	Reason for the Denial	Request PA
Tablet Splitting	19 – M/I DAYS SUPPLY Additional text: MUST SPLIT TABLETS	Certain medications that are scored and easily halved should be split to facilitate more cost-effective use of the drugs.	If the patient is unable to break the tablets or the dose cannot be achieved by switching tablet strength.

- For example, a prescription filled for Lexapro® 5mg for a quantity of 30 tablets for a 30 days supply would need to be changed to Lexapro® 10mg for a quantity of 15 tablets for a 30 days supply with the directions to take one-half tablet (5mg) daily.
- If the drug regimen cannot be altered, the prescriber must complete the Quantity Limit Override Prior Authorization form located at www.iowamedicaidpdl.com under the PA Forms link. The prescriber may submit the prior authorization request prior to the January 1, 2009 effective date.

5. **ProDUR Quantity Limits:** The following quantity limit edits will be implemented. A comprehensive list of all quantity limit edits appears on our website, www.iowamedicaidpdl.com under the heading, "Quantity Limits". It is recommended that the list below be reviewed and medications prescribed outside of these dose consolidation edits be adjusted prior to the implementation.

Drug Product	Quantity	Days Supply
Glucagen	5	30
Lexapro® 5mg	15	30
Lexapro® 10mg	15	30

- For 5mg Lexapro® dose use ½ - 10mg tablet
- For 10mg Lexapro® dose use ½- 20mg tablet

6. **Synagis® Coverage 2008-09 RSV Season**
Prior authorization requests for Synagis® may be currently submitted to the Iowa Medicaid Pharmacy Prior Authorization Unit. Approved Synagis® prior authorizations will have a start date of October 30, 2008. Prior authorizations will be approved for a maximum of five doses through March 31, 2009. An additional sixth dose may be required based on variations in season patterns.

7. **Flu Vaccines for 2008-09 Flu Season**
Flu vaccines for members 6 months through the age of 18 should be referred to the Vaccines for Children Program (VFC) at 800-831-6293. For more information regarding this program, please refer to the website below.

http://www.idph.state.ia.us/adper/common/pdf/immunization/vfc_policy_statement.pdf

8. **Programming Update**
The programming for Concurrent IM/PO Antipsychotic Use to be effective October 27, 2008 has been delayed.

We encourage providers to go to the website at www.iowamedicaidpdl.com to view all recent changes to the PDL. If you have questions, please contact the Pharmacy Prior Authorization Helpdesk at 877-776-1567 or 515-725-1106 (local in Des Moines) or e-mail info@iowamedicaidpdl.com.